

**ACHIEVE CENTER
PATIENT CONSULTATION REQUEST**

Achieve Center
2600 Stewart Ave, Suite 38
Wausau, WI 54401
Phone: 715-845-4900
Fax: 715-845-4970

Patient Name _____ DOB: _____

Patient Phone Number: _____

Parent Name: _____

Address: _____

Please include with this consultation request as available:

- Copy of newborn records and newborn screening results
- Copy of growth chart.
- Copy of recent well child check up- please have current (within one year).
- Copy of developmental or behavioral screening tools and results
- Copies of subspecialty evaluations
- Copy of signed Release of Information Form for entire medical record
- Copy of Client Demographic Information sheet

Please State:

1. The main reason I am seeking consultation for this patient is:

2. The secondary issues are:

3. Family dynamics to be aware of are:

4. I am specifically seeking:

- _____ Patient's specific needs to be determined by Achieve Team
- _____ Developmental Pediatric Assessment
- _____ Neuropsychological Assessment
- _____ Psychological Assessment (mood and behavior evaluation)
- _____ Behavioral/cognitive treatment, parent training and counseling services for patient and family

I prefer to receive feedback:

- _____ By receiving a full report from the Achieve Team
- _____ Summary of findings and recommendations (this would get to you quicker)

Signature of Physician: _____ Date: _____

Print Physician's Signature: _____

Clinic Name: _____ Phone #: _____

Rev. 03/12 Fax #: _____